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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **HAYDEE QUITORIANO PARUNGAO,** **a.k.a. HAYDEE QUITORIANO ISIDRO,** **a.k.a. HAYDEE Q. PARUNGAO,** **a.k.a. HAYDEE T. QUITORIANO,** **a.k.a. HAYDEE PACIA,** **a.k.a. HAYDEE Q. PACIA** **225 West 3rd Street, #126** **Long Beach, CA 90802** **Registered Nurse License No. 322427** Respondent.	Case No. 2010-129 **ACCUSATION**

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about October 31, 1980, the Board issued Registered Nurse License Number 322427 to Haydee Quitoriano Parungao, also known as Haydee Quitoriano Isidro, Haydee Q. Parungao, Haydee T. Quitoriano, Haydee Pacia, and Haydee Q. Pacia ("Respondent"). Respondent's registered nurse license expired on November 30, 2008, and has not been renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> . . . .
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> (f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof . . .

6. Code section 2765 states:

> A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions and duties of a registered nurse is deemed to be a conviction within the meaning of this article. The board may order the license or certificate suspended or revoked, or may decline to issue a license or certificate, when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information or indictment.

7. Code section 490, subdivision (a), states:

> In addition to any other action that a board is permitted to take against a licensee, a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

8. California Code of Regulations, title 16, section 1444, states, in pertinent part:

> A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a

manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

. . . .

(c) Theft, dishonesty, fraud, or deceit . . .

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Criminal Conviction)

10. Respondent is subject to disciplinary action pursuant to Code sections 2761, subdivision (f), and 490 in that on or about May 15, 2006, in the criminal proceeding titled *U.S. v. Haydee Parungao*, etc. (U.S. Dist. Ct. Central Dist. of CA, 2006, Case No. CR 06-373-DSF), Respondent pled guilty to five counts of health care fraud, in violation of 18 U.S.C. section 1347 (class C felonies), and four counts of structuring financial transactions, in violation of 31 U.S.C. section 5324, subdivision (a)(3) (class D felonies), crimes substantially related to the qualifications, functions, and duties of a registered nurse.

11. On or about March 28, 2007, Respondent was sentenced to serve 57 months in state prison on all counts (to be served concurrently), and upon release from imprisonment, was ordered to be placed on supervised release or probation for a period of three (3) years on terms and conditions. Respondent was also ordered not to be employed in any position requiring licensing or certification by any local, state, or federal agency without prior approval of the Probation Officer, and to pay restitution in the amount of $3,009,835.89 to the Centers for Medicare and Medicaid Services.

12. The circumstances of the crimes are as follows: At all times relevant herein, Respondent was purported to provide in-home nursing services to Medicare patients. Respondent worked as an independent contractor for a number of different home health agencies, including Provident Home Health Care Services, Inc. ("Provident"), Tri-Regional Home Health Care, Inc.

("Tri-Regional"), Datacare Home Health Services, Inc. ("Datacare"), and Double Diamond Home Health Services ("Double Diamond"). Provident, Tri-Regional, Datacare, and Double Diamond were Medicare providers. Between approximately January 1, 2001, and August 2004, Respondent and others (known and unknown) knowingly, willfully, and with intent to defraud, executed and attempted to execute a scheme to defraud Medicare in connection with the delivery of and payment for health care benefits, items, and services in the following manner:

a. Respondent would recruit Medicare beneficiaries who were willing to sign up for home health services. Respondent would induce Medicare beneficiaries to accept home health services and to sign paperwork for such services by paying them cash or giving them gifts.

b. Respondent would market these Medicare beneficiaries to various home health agencies that were Medicare providers, including Provident, Tri-Regional, Datacare, and Double Diamond.

c. The home health agencies would pay Respondent approximately $1,000 to $1,700 per beneficiary per episode for intermittent care and approximately $3,500 to $5,000 per beneficiary per episode for twice a day (BID) care.

d. Respondent would enroll the beneficiaries with the home health agencies whether the beneficiaries met the criteria for Medicare reimbursement or not. Specifically, Respondent would enroll beneficiaries even though they were not confined to the home and even though they did not need skilled nursing or therapy services.

e. Respondent would falsify the OASIS (Outcome and Assessment Information Set)[1] forms to make it appear as though: (a) she conducted a complete evaluation of the beneficiaries, when, in fact, she had not; (b) the beneficiaries were homebound, when, in fact, they were not; and (c) the beneficiaries' medical condition and lack of willing caregivers made home health services medically necessary when, in fact, they were not.

[1] To determine the proper level of care for a particular beneficiary and ultimately to help determine the amount of payment, Medicare required that home health agencies perform an initial evaluation, which is a patient-specific, comprehensive assessment that accurately reflects the patient's current health and provides information to measure his or her progress. In making this assessment, home health agencies were required to use a tool called the Outcome and Assessment Information Set (OASIS).

f. Respondent would purport to visit beneficiaries on the schedules set forth in their plans of care, but did not, in fact, do so.

g. Respondent would falsify daily route sheets and skilled nursing notes to make it appear that she had visited patients when she had not, and to make it appear that visits she did make lasted longer than they, in fact, were.

h. The daily route sheets and skilled nursing notes would reflect nursing visits that Respondent had not made, including:

i. visits to multiple different patients at different locations at the same time;

ii. visits while Respondent was, in fact, in the Philippines and other locations outside of Southern California;

iii. visits while Respondent was gambling at Pechanga, San Manuel, and other casinos;

iv. visits while Respondent was cashing the checks she received from home health agencies;

v. visits far in excess of the number a nurse can actually make.

i. Between January 1, 2001, and August 2004, Respondent purportedly made over 18,000 home health visits. The majority, 10,050 of these visits, took place between April 1, 2002 (when Respondent started at Provident), and August 31, 2003 (after which Provident and Tri-Regional ceased operations). Respondent would prepare and sign daily route sheets and skilled nursing notes for these visits, indicating that she personally made the visits and that the visits lasted 45 minutes to an hour each. The false records that Respondent created would show that Respondent purported to work every single day during this seventeen month time period when she was working with Provident and Tri-Regional, including all weekends and holidays; averaged 20 visits a day; and saw multiple patients in different locations at the same time.

j. Respondent made two trips to the Philippines from April 30, 2002, through May 14, 2002, and April 19, 2003, through April 27, 2003. Respondent would create falsified clinical records showing that she made over 160 visits during these time periods when she was, in fact, outside of the United States.

k. Respondent would rotate patients among different home health agencies and would submit falsified clinical records including false OASIS forms, daily route sheets, and skilled nursing notes, to different home health agencies, thereby spreading out the number and volume of claimed visits among different agencies.

l. Respondent would submit the falsified clinical records to the home health agencies knowing and intending that they would be used to submit false claims for payment to Medicare.

m. As a direct and intended result of Respondent's conduct, the home health agencies would submit false claims for payment to Medicare. The home health agencies would bill Medicare for home health services to beneficiaries who were not confined to their homes and other beneficiaries who did not qualify for or need home health services. The home health agencies would also bill Medicare for services to beneficiaries who did not, in fact, receive the services billed.

n. Medicare would pay the claims based on the false information and representations regarding the beneficiaries' medical condition and the number of visits purportedly made.

o. The agencies would pay Respondent.

p. By means of the above-described conduct, Respondent would cause the home health agencies to submit to Medicare and would cause Medicare to pay false and fraudulent claims for approximately 573 episodes of home health services to approximately 368 beneficiaries between January 1, 2001, and September 30, 2004, thereby causing a loss to Medicare in excess of approximately $3,009,835.89.

13. Further, Respondent and others (known and unknown), for the purpose of executing the scheme to defraud described above, knowingly and willfully caused to be submitted to Medicare the following false and fraudulent claims:

COUNT	PATIENT	CLAIM NUMBER	HOME HEALTH AGENCY	DATE CLAIM SUBMITTED	AMOUNT PAID
ONE	L.J.	20121500673702	Datacare	8/2/2001	$9,786.93
TWO	E.G.	20232702456002	Provident	11/22/02	$6,059.62
THREE	C.G.	20308402378402	Tri-Regional	3/24/2003	$4,674.81

COUNT	PATIENT	CLAIM NUMBER	HOME HEALTH AGENCY	DATE CLAIM SUBMITTED	AMOUNT PAID
FOUR	L.P.	20318900005202	Provident	7/7/2003	$8,280.61
FIVE	M.J.	20314202574902	Tri-Regional	5/21/2003	$8,492.74

14. In addition, on the dates set forth below, Respondent knowingly and for the purpose of evading the reporting requirements of section 5313, subdivision (a), of Title 31, United States Code, and the regulations promulgated thereunder, structured and attempted to structure the following transactions involving Wells Fargo Bank, a domestic financial institution:

COUNT	DATE	DESCRIPTION OF TRANSACTION
SIX	10/31/02	Cashed Provident check #8327 dated 10/30/2002 for $9,050 at 1200 Wilshire Blvd., Los Angeles branch at approximately 5:26 p.m.
SEVEN	10/31/02	Cashed Provident check #8328 dated 10/30/02 for $9,050 at 707 Wilshire Blvd., Los Angeles branch at approximately 5:54 p.m.
EIGHT	3/7/03	Cashed Tri-Regional check #2414 dated 3/7/03 for $8,640 at 12160 Victory Blvd., North Hollywood branch at approximately 12:53 p.m.
NINE	3/7/03	Cashed Provident check #2415 dated 3/7/03 for $8,640 at 900 N. San Fernando Blvd., Burbank branch at approximately 3:40 p.m.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 322427, issued to Haydee Quitoriano Parungao, also known as also known as Haydee Quitoriano Isidro, Haydee Q. Parungao, Haydee T. Quitoriano, Haydee Pacia, and Haydee Q. Pacia;

2. Ordering Haydee Quitoriano Parungao, also known as also known as Haydee Quitoriano Isidro, Haydee Q. Parungao, Haydee T. Quitoriano, Haydee Pacia, and Haydee Q.

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Pacia, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/28/09

Louise R. Bailey

LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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